The

INSIDE STORY®

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What's Inside

WE VALUE HEALTH CARE...

BUT IS IT IN FACT DELIVERING VALUE?

The current upward trajectory of rising costs in health care seems to be taking us down an unsustainable path, making it more essential than ever we get value for our health care investments. However, not only is value often not there, but also it seems that we don't even expect it, let alone demand it. Although we are focused on value in other parts of our lives—like our TV/phone/internet packages—we don't seem to examine health care with the same critical lens.

Value in health care = the best quality for the lowest price

Our health care system is a source of pride for many Canadians, but how is it doing—is value *really* there? Value means that it's not enough that a health care product, service, organization, or provider just deliver *something*—it's about the quality and outcome of that something. The idea is that every investment in health care—whether dollars spent on hospital infrastructure or paying health care professionals or providing plan members with health benefits—should produce a high-quality outcome relative to its costs.

For instance, the waiting room at the doctor's office certainly was aptly named; it never ceases to meet our expectations to wait—and wait and wait—but is this good value? Are our expectations too low in terms of quality and demanding value for our money?

Recent headlines would suggest that indeed we have set the bar pretty low, as we don't seem to be cutting it regarding a range of important quality indicators. As the National Post reports, "Canada's health care wait times get failing grade in survey of 11 industrialized countries."[1] A study by the Commonwealth Fund in collaboration with the Canadian Institute of Health Information (CIHI) conveys that compared to 11 other countries, patients interviewed in 2016 reveal that Canada is significantly below the international average on seven out of eight measures of timely access to care.[2]

Canada? Not so good...

Data for 2016 indicates that compared to 11 other countries, Canada...

- → Has the highest proportion of patients with long delays to see specialists.
- → Has emergency room wait times almost three times the international average.
- → Tied for last place in terms of Canadians being able to get same-day or next-day appointments with their family doctors.
- → Placed second-last regarding the availability of doctors at night or over the weekend; this contributed to Canadians as the most frequent users of emergency departments, as well as the most likely to wait four hours or more for emergency care.[3]

Even once you are seen by a doctor, in some cases, standardization of care is an issue. For example, the rate of C-sections varies across Greater Toronto Area hospitals: there is more than a one-in-three chance of having a C-section in one hospital versus less than a one-in-four chance at another one.[4]

In addition, waiting for a spot in long-term care varies greatly depending on the region and the desired placement. The wait can be more than 2,000 days—that's five and half years.[5]

And 138,000 patients—one in every 18 patients—admitted to a Canadian hospital in 2014/15 suffered some sort of preventable harmful event like getting the wrong drug or developing an infection. Of these 138,000 patients, 17,300—or one in eight—died while in hospital.[6]

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Not good.

But maybe we can argue that at least the system is improving. Along these lines: if population health is improving, then the system must be improving. Unfortunately, health outcomes statistics show otherwise...

A CIHI study that compared Canada's performance regarding premature mortality with the performance of 17 other OECD countries from 1960 to 2010 reveals that "although Canada has made substantial improvements in population health over the last 50 years, compared with peer countries, its relative position remains unchanged."[7]

For instance, although there has been an improvement in mortality due to heart disease over the study's 50 years, Canada still fell behind the international average in 2010.[8] In addition, when looking at cancer overall, although Canada experienced a reduction in mortality, in 2010 the mortality of Canadian women due to cancer still lagged behind relative to other women internationally.[9]

Needless to say, it would not be an understatement to say that Canada is not getting the best value for its health care expenditures. And now with rising costs, the system must demand value. Here's how...

You can't change what you don't measure

Health systems around the globe recognize that measuring, reporting, and adapting is the best way to drive system change and create value. Of course, this process has its own snazzy acronym—QI—for quality improvement. In fact, QI isn't a new field, its roots lie in the automotive and technology sectors. A range of broad QI initiatives are common across many health care systems including:

- → Mandating public reporting of results regarding specific performance indicators
- → Tracking and reporting wait times
- → Certifying health care organizations
- → Training and licensing health care professionals
- → Establishing organizations specifically focused on quality improvement
- → Centralizing corporate services and developing centres of excellence in large health care organizations to promote efficiency

Developing a culture of QI in Canada

- → The *2003 Accord on Health Care Renewal* set out agreements between the federal government and the provinces and territories to improve health care.
- → New initiatives began cropping up with a focus specifically on QI to varying degrees. For instance, in 2010 the Ontario government passed legislation specifically focused on QI in health care called *The Excellent Care for All Act*.
- → Today, some provinces have health quality organizations—like Health Quality Ontario, the Saskatchewan Health Quality Council, and the Health Quality Council of Alberta—other regions have their QI functions mainly within their health ministries.
- → In addition, a team of Canadian physicians in partnership with the Canadian Medical Association launched *Choosing Wisely Canada*. It is a campaign to help clinicians and patients engage in conversations about unnecessary tests and treatments and make smart and effective choices to ensure high-quality care.

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Examining and adapting reimbursement models is another area of QI that aims to drive value. And wait for it... yes, another acronym: P4P or "pay for performance" (also referred to as "performance-based funding," "paying for results," "results-based financing," or "outcome-based reimbursement").

P4P reimburses health care providers based on achieving certain quality indicators as a way to better align payment of health care providers with improved quality of care and health outcomes. As the World Health Organization explains, "Pay for performance programs are based on the premise that if health care providers are paid more for certain behaviours, processes, and outcomes, then more of these will be delivered."[10]

For instance, primary care physicians and specialists may receive reimbursement or bonuses for reaching performance targets around preventive care, efficiency of care, patient satisfaction, and management of chronic diseases. Hospitals may receive reimbursement, bonuses, or even penalties for their processes and procedures for care, and also to some degree for clinical outcomes and patient satisfaction.

Most OECD countries are implementing some form of P4P in the health sector. A 2012 study indicates that P4P exists in 15 OECD countries in the following areas of health care: primary care physicians (all 15 countries), specialists (eight countries), and hospitals (eight countries).[11]

One of the most well-known P4P examples is in the United Kingdom, which has the most comprehensive national primary care P4P program in the world, where physicians are held accountable for meeting targets related to quality indicators, and a large component of their compensation comes from meeting those targets. And in the United States, P4P reimbursement for pharmacies is a growing trend as health plans increasingly include performance-based incentives for pharmacies that meet certain benchmarks.

In Canada, some provinces have moved to a model where doctors can still retain their own practices but now share responsibilities with other doctors in what are called Family Health Teams. The doctors are paid using a blended capitation model that combines the payment models of capitation and fee-for-service. Here's how it works: the doctor receives a base payment for each patient enrolled in the practice. Some patients require more care than others, so the amount per patient is adjusted to account for the patient's health needs, age, and sex. The doctor also receives payment via fee-for-service for any patients not enrolled in the practice. Ideally, this approach promotes quality because it encourages doctors to keep patients healthy as there is no additional income when patients are sick. Also, the team approach should encourage collaboration as another way to lead to better health outcomes.

QI in health care around the globe

- → **United States:** Ideas like accountable care organizations made up of a range of health care providers who are held responsible for costs and health outcomes.
- → **England:** Policies and initiatives to promote choice and competition throughout the health care system, as well as shift the emphasis from performance management to clinical outcomes.
- → **The Netherlands:** Changes to the health insurance market to improve quality, efficiency, and customer responsiveness.
- → **Australia:** Small hospital networks run by local health care providers with performance a major part of the funding equation.
- → **Mexico:** Consolidation of drug purchasing to promote competitiveness in terms of drug quality and costs.
- → **China:** New digital health technologies to improve efficiency as part of a shift in focus from the volume of health care services to providing higher quality care.

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In the quest for value in health care, there is consensus that QI is definitely the way to go. However, how QI translates into better health outcomes and lower costs continues to evolve as there are so many variables involved in each QI initiative: the area for improvement, the health care sector, the health provider, the patient population, the health condition, and so on and so on. Some areas are showing improvement, and the idea is that quality improvements in different areas should accumulate, leading to improvements in health outcomes overall.

We all need to look into the mirror

In terms of the health benefits industry, maybe we need to be more aware about providing value too. At GSC, over the last couple of years, we've been asking ourselves some tough questions. We broadened what in the past were our drug studies, to now also include a look at extended health benefits. This way, our health studies also examine usage of extended health care services with questions like: is there really evidence to support, and is there value in, massage treatments for teenagers and chiropractic services for babies?

As health costs continue to rise, it might be time to also examine payment models. For example, the reimbursement model for health care providers is typically payment for time rather than payment for the quality of the service or the service outcome. Likewise, we reimburse for dental services based on procedure or time, not quality. How do we really know that we're getting value for these services? We don't.

And although we continue to implement a range of cost containment strategies, they are mostly focused on drugs, and not all plan sponsors take advantage of them. It's time to step it up a notch and put reimbursement models under the microscope.

When it comes to boosting the value of benefits dollars…

As loyal readers of *The Inside Story*, you know all too well that GSC has always been into data (like really into it)—and that we have been encouraging (OK, more like strongly insisting) plan sponsors to assess whether they are investing in health care services that deliver value and results. Now we're stepping up our quality improvement efforts a notch by grouping all of our cost management strategies under a new banner called *SMARTspend* to emphasize how they deliver value.

Keep your eye out for an upcoming *GSC Update* where we'll introduce a new SMARTspend initiative—Value-based Pharmacy Management.

[1,2,3]"Canada's health-care wait times get failing grade in survey of 11 industrialized countries," Sheryl Ubelacker, National Post, February 16, 2017. Retrieved May 2017: news.nationalpost.com/news/canada/canada-ranks-low-in-international-comparison-of-patient-wait-times-report.

[4]"C-section still high at some hospitals," Theresa Boyle and Megan Ogilvie, Toronto Star, April 5, 2012. Retrieved May 2017: www.thestar.com/news/gta/2012/04/05/csection_still_high_at_some_hospitals.html.

[5]"Ontario's long-term care problem: Seniors staying at home longer isn't a cure for waiting lists," Blair Crawford, National Post, March 12, 2016. Retrieved May 2017: news.nationalpost.com/news/canada/ontarios-long-term-care-problem-seniors-staying-at-home-longer-isnt-a-cure-for-waiting-lists.

[6]"1 in 18 Canadian hospital patients experience harm from preventable errors: study," Sheryl Ubelacker, The Canadian Press, October 26, 2016. Retrieved May 2017: globalnews.ca/news/3026275/1-in-18-canadian-hospital-patients-experience-harm-from-preventable-errors-study/.

[7,8,9]*50-Year Study Finds Canadian Women Falling Behind on Potential Years of Life Lost*, Canadian Institute of Health Information, 2016. Retrieved May 2017: www.cihi.ca/en/50-year-study-finds-canadian-women-falling-behind-on-potential-years-of-life-lost.

[10,11]*Paying for Performance in Health Care, Implications for health system performance and accountability*, World Health Organization, 2014. Retrieved May 2017: www.euro.who.int/__data/assets/pdf_file/0020/271073/Paying-for-Performance-in-Health-Care.pdf.

COMMUNITY GIVING PROGRAM

HERE'S HOW WE **ADD** TO THE **GREATER GOOD**…

Frontline care—like dental services, vision care, prescription drugs, disease management, and mental health supports—can act as a catalyst for change. That's why the GSC Community Giving Program is focused on supporting organizations and initiatives that provide frontline care for underinsured or uninsured populations. And all grant recipients include a navigator component—this means ongoing positive change as clients are referred to any additional services they may need.

GSC frontline care™

Frontline care in action

Education Foundation of Niagara – Medical Needs Fund

In the Niagara region of Ontario, the reduction in high-paying manufacturing jobs—combined with the rising costs of living—means that many families are struggling financially. As a result, numerous children experience barriers to succeeding at school because they are living in poverty. Sometimes families are forced to choose between paying for rent and other necessities like nutritious lunches, school supplies, and clothing that fits. The Education Foundation of Niagara reduces these challenges for disadvantaged students in junior kindergarten to grade 12 who attend schools in the District School Board of Niagara (DSBN). Through donations from generous individuals and organizations, the Foundation fills the gaps where sources of government funding aren't available to help students access all of the enriching opportunities that school life has to offer. For example, the Foundation helps students afford healthy food, winter clothes, proper footwear, personal care items, and school supplies, as well as school-based extracurricular activities and field trips.

Addressing essential medical needs

Responding to an increase in applications related to medical necessities, the Foundation launched their Medical Needs Fund. Now at DSBN schools, teachers, youth workers, and counsellors—often in consultation with public health professionals—act as navigators helping students get necessary medical services and products. For example, eligible students receive glasses, epinephrine auto-injectors for allergic reactions, and a range of prescription drugs where other funds are not available. Support is provided not only in regards to physical health, but also for emotional and mental health issues. As a result, in addition to receiving financial assistance for medical expenses, students are also connected to a range of community resources.

Supporting health as the foundation for a brighter future

With funding from GSC, the Foundation made their new Medical Needs Fund a reality. The Foundation awards funding to individuals after reviewing student applications for financial assistance that are submitted by school personnel. Accordingly, the higher the donations from individuals and organizations, the greater the number of students the fund can help. GSC's support enabled the Foundation to launch the fund, thereby letting numerous individual students receive essential medical services and products. This support for physical, emotional, and mental health will not only help set students up for academic success, but ultimately will also pave the way for a brighter future. To learn more, visit www.efnniagara.ca

What's UP...

UPDATE ON OPIOIDS

As you may recall, the November 2016 edition of *The Inside Story* focused on what is widely referred to as Canada's opioid crisis. You may also recall that consensus is that there is no single solution to the crisis—the crisis must be tackled on all fronts. Now we have an update on this situation as the federal government takes action with a new law, and a new study in Ontario emphasizes the magnitude of the opioid issue.

Federal: New law gives immunity for those who call 911 regarding a drug overdose

The federal government has passed the *Good Samaritan Drug Overdose Act* into law. This new law aims to reduce the number of people who die from opioid and other drug overdoses by providing immunity for people who call 911 for themselves or another person suffering an overdose, as well as anyone who is at the scene when emergency help arrives.

If medical attention is received quickly, many drug overdose deaths are preventable. However, many people do not call 911 because they are afraid they will be charged with drug possession. The new act aims to save lives by exempting them from charges of simple possession of a controlled substance and from charges if they are on a probation order, serving a conditional sentence, or on parole.

This new law is part of the federal government's goal of building a new approach to drug policy that includes collaboration among all government sectors and key stakeholders—like addiction experts and the medical community, first responders, Indigenous groups, non-governmental organizations—as well as Canadians who have experienced drug issues first-hand either through their own direct experience or via others in their lives.

For more information, visit www.canada.ca/en/health-canada/news/2017/05/good_samaritan_drugoverdoseactbecomeslawincanada.html.

Ontario: Nine million opioid prescriptions filled in Ontario

A new report by Health Quality Ontario—called *9 Million Opioid Prescriptions*—indicates that nearly two million people in Ontario fill prescriptions for opioids every year. This translates into 14% of the population—that's one in every seven. People in Ontario filled more than nine million prescriptions for opioids in 2015/16. This is up from 450,000 prescriptions from three years earlier. In addition, the report conveys that the opioids being prescribed have shifted away from weaker opioids like codeine toward stronger types like hydromorphone, which is used to treat severe pain but is approximately five times stronger than morphine. This increased by nearly 30% over three years, to almost 259,000 people, from just over 200,000.

For more information and to download the report, visit www.hqontario.ca/System-Performance/Specialized-Reports/Opioid-Prescribing.

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NEW REPORTS INVESTIGATE THE VALUE OF ADDITIONAL COMMUNITY PHARMACY SERVICES

In recent years, many Canadian jurisdictions have expanded the scope of community pharmacy services. The Conference Board of Canada's 2016 report called—*A Review of Pharmacy Services in Canada and the Health and Economic Evidence*—examined this expanded scope from several perspectives, including the additional services within community pharmacies and the impact these services have on Canadians, as well as on the sustainability of our health care system. Now the Conference Board has released two more related reports:

- *The Value of Expanded Pharmacy Services in Canada*—This second report assesses the health and economic impact of three community pharmacy services that could be implemented across Canada: smoking cessation, pneumococcal vaccination, and advanced medication review and management for cardiovascular disease. Findings include that scaling up advanced medication review and management for cardiovascular disease could generate cost savings between $1.9 billion and $19.3 billion. And expansion of all three services could result in cumulative savings of between $2.5 and $25.7 billion over the next 20 years, depending on the level of uptake. Preventing chronic conditions and premature death are some of the health benefits of expanding these services. For more information and to download the report, visit www.conferenceboard.ca/e-library/abstract.aspx?did=8721.
- *Getting the Most Out of Community Pharmacy: Recommendations for Action*—This third and final report in the series investigates the policy, practice, and research challenges associated with the expansion of pharmacy services in Canada identified in the first two reports. It recommends a range of opportunities to optimize community pharmacy including enhancing evidence and understanding of the potential impact of expansion, addressing the perceived challenges associated with legislation and regulation of the pharmacy profession, creating supportive operating environments, supporting the monitoring and evaluation of pharmacy practice quality standards, and identifying and implementing appropriate funding models for expanded pharmacy practice. For more information and to download the report, visit www.conferenceboard.ca/e-library/abstract.aspx?did=8796.

AND IN OTHER NEWS ABOUT PHARMACY PRACTICE…

Regarding other ways pharmacists are in the news lately, eHealth Ontario has launched the first ePrescribing program with pharmacists at two sites in Ontario, ideally paving the way for a province-wide program. ePrescribing eliminates hand-written prescriptions by enabling doctors to send prescriptions electronically to pharmacies. For more information, visit https://www.ehealthontario.on.ca/en/news/view/canadas-first-eprescribing-program-launches-in-ontario.

OUT & ABOUT… *Events not to miss*

We're still on the road with the GSC 2017 Health Study: *Come Health or High Water*

Don't forget to come out and learn what the data is saying about strategies to keep health benefits plans afloat in the wake of numerous industry developments. The latest and greatest claims data analysis and research will provide important insights.

We look forward to seeing you there.

TORONTO (AGAIN!)	**JUNE 22**
VICTORIA	**SEPTEMBER 13**
KELOWNA	**SEPTEMBER 14**

Healthy Outcomes Conference – June 13-14, 2017

Shangri-La Hotel, Toronto, Ontario
http://www.benefitscanada.com/conferences/healthy-outcomes-conference
Peter Gove will be speaking about inspiring employers to move towards healthier outcomes. GSC is an event sponsor.

June Haiku

We spend without proof
Of any downstream outcomes
SMART spend is coming soon

FITBIT WINNER

Congratulations to **R. KWOK-WAI NG**, of **Ajax, ON**, the winner of our monthly draw for a Fitbit. Through this contest, one name will be drawn each month from plan members who have registered for Plan Member Online Services for that month.

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